Arizona 1115 Waiver Amendment Request
Integration of Behavioral and Physical Health Services

I. Summary

Arizona is requesting an amendment to the language found in Waiver #1 as it relates to the provision of behavioral health services for acute care enrollees as found in its current 1115 Research and Demonstration Waiver List. Waiver #1 waives the State from requirements found in Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56. This authority permits the State to limit acute care enrollees in the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, to a single Prepaid Inpatient Health Plan (PIHP) – the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) – for the treatment of behavioral health conditions.

The State's current Waiver authority reflects a health care delivery system that has carved out behavioral health services. The State seeks to amend Waiver #1 to allow for integration of physical and behavioral health services for a select population by requiring the ADHS/DBHS to serve as the only managed care plan for both acute and behavioral health conditions for AHCCCS acute care enrollees with Serious Mental Illness (SMI) in Maricopa County. This request also seeks to at least maintain alignment for dual eligibles with SMI who are currently enrolled in acute care health plans that are also Special Needs Plans (SNPs) by requiring the ADHS/DBHS subcontractor to become a SNP and passively enrolling those dual eligibles into the new SNP.

The request is intended to allow the State to:

- Transform care for individuals with SMI by operating a fully integrated health care system that would enroll individuals with SMI into one entity via ADHS/DBHS that would manage their physical and behavioral health and that would also serve as a Special Needs Plan for those individuals with SMI that are dual eligibles.
- Improve care coordination and health outcomes for individuals with SMI in Maricopa County.
- Increase the ability of the ADHS/DBHS to collect and analyze data to better assess the health needs of their members with SMI from a holistic approach.
- Streamline the current fragmented health care delivery system, which has caused individuals with SMI to receive physical health care in a manner that has not maximized efficiencies and provided for the best coordination of care, contributing to poorer health outcomes.
- Reduce costs by, among other things, decreasing hospital admissions and readmissions, shortening lengths of stay when hospitalization is needed and increasing participation in wellness, prevention and disease management and recovery programs.
- Promote the sharing of information between physical and behavioral health providers to work as a team and manage treatment designed to address an individual's whole health needs.

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This request follows recommendations made by Secretary Sebelius in a letter to Arizona Governor Jan Brewer dated February 15, 2011 wherein she recommended that the State integrate behavioral and physical health services. The State agrees with the Secretary's recommendation and is pursuing this course in an incremental fashion focusing first on the adult population with SMI in Maricopa County by weaving physical health care requirements into the existing behavioral health structure.

II. Overview

Discussing Integration in Arizona

Arizona's public system of care for the treatment of behavioral health conditions pre-dated the State's participation in the Medicaid program. When the State joined the Medicaid program in 1982, it incorporated behavioral health services over time as part of the Medicaid benefits package but maintained a separate system of care for the treatment of behavioral health needs. This separation was maintained at the request of community stakeholders who believed that a system focused solely on behavioral health was better suited to meet the behavioral health needs of AHCCCS enrollees. It was also believed that a carved out approach would better preserve behavioral health funding. Today, the AHCCCS program serves over 15,000 members with SMI in Maricopa County.

Meanwhile, Arizona's managed care model has evolved and matured, providing quality care at a modest cost. This success moved the State to adopt an integrated approach in the AHCCCS Arizona Long Term Care System (ALTCS), which serves members at-risk of institutionalization. Health plans in the ALTCS system manage the physical and behavioral health care needs of AHCCCS long term care members, while also serving as Special Needs Plans, allowing ALTCS contractors to coordinate care for those dually eligible in Medicaid and Medicare. The ALTCS system, which has over 74% of its elderly and physically disabled members living at home or in the community, has served as a national model for quality, cost efficiency and integration of care.

Arizona's ALTCS model has proven that integration of behavioral and physical health is not only achievable but also successful. The State recognizes, however, that the ALTCS model may not be the best approach in terms of creating an integrated system of care for the AHCCCS acute care population.

As the national focus looks toward integrating care and at the urging of the Secretary, Arizona began to consider its options related to integration of behavioral health services. As part of this process, the State applied for and was awarded planning grant funding from the Centers for Medicare and Medicaid Services (CMS) under Section 2703 of the Affordable Care Act. Section 2703 focuses on a health home approach to care delivery for individuals with chronic illness. Because of the unique needs of individuals with SMI, the State determined that the health home approach

would be of great benefit but that such an approach could only thrive if it was part of an integrated model at the administrative/health plan level[1].

Even with the successes achieved in the ALTCS model, the State was sensitive to remaining stakeholder concerns about integrating behavioral health services into the AHCCCS acute care model. Therefore, the discussion of integration shifted to moving physical health care delivery and oversight to the entity responsible for the provision of behavioral health – that is, move physical health under the purview of ADHS/DBHS. Because this does represent a shift in the carved out approach of behavioral health and the State is coupling this shift with a health home model, it was decided that an incremental approach was best. This incremental approach would focus on ADHS/DBHS being responsible for the provision of physical and behavioral health care services for individuals with SMI in Maricopa County.

Why Individuals with Serious Mental Illness?

In Arizona, persons determined to have SMI die 25 to 30 years earlier than persons in the general population. More often they die, not from anything related to their behavioral health condition, but due to physical health problems, such as diabetes, heart disease, respiratory disease and other preventable or manageable physical illnesses. Many individuals with SMI experience poorer physical health outcomes because they simply are unable to navigate the fragmented and complex health care systems to receive the care they need for their physical illnesses. By creating greater alignment at the health plan level and supporting that structure through a health home concept, the State can take important steps to address the health disparities that exist for this population.

Amending Arizona's 1115 Waiver to Achieve Integration

Without aligning the financial incentives, there simply will not be an adequate connection between the acute care delivery system and the behavioral health care system. This means that integration must first be achieved at the administrative level, by making one entity responsible for the physical and behavioral health needs of individuals with SMI in Maricopa County. This type of structure would leverage the State's managed care infrastructure and maximize care coordination allowing one responsible entity to have access to all of the necessary data to target best practices for improving health outcomes within the identified population. In Arizona, that entity is the ADHS/DBHS, which serves as AHCCCS' contractor for behavioral health services to AHCCCS acute care enrollees.

The amendment to the current Waiver is needed in order to add the management of physical health care for members with SMI in Maricopa County to the responsibilities

[1] The term "health plan" is used generically to reference an entity responsible for managing the care of its members. It is not meant to refer only to AHCCCS acute care health plans, but is broad enough to include entities that currently manage the behavioral health needs of their members, such as Regional Behavioral Health Authorities (RBHAs).

of ADHS/DBHS. This means that those members with SMI would only be able to receive their physical health care through ADHS/DBHS, which is an expansion of the State's existing waiver authority.

In order to fully integrate services for this discrete population, the Waiver amendment will need to recognize that many individuals with SMI are also enrolled in Medicare and are dual eligibles. In Arizona, there are approximately 31,989 AHCCCS enrollees with SMI; 15,680 reside in Maricopa County. (See Attachment 1 describing AHCCCS SMI Medicare enrollment.) Of the 15,680 AHCCCS members with SMI, 6,762 are also enrolled in Medicare; 43% of the SMI population in Maricopa County is dually eligible. Currently, 3,485 of these SMI duals are in aligned plans for Medicaid acute and Medicare services, as they are being served by AHCCCS acute care health plans that are also Special Needs Plans (SNP).

The State is working with the CMS Medicare-Medicaid Coordination Office to develop a proposal for alignment of dual eligibles under the three-way contracting structure. As that process continues to unfold and develop, however, the State wishes to maintain its current alignment by requiring the new ADHS/DBHS subcontractor to become a SNP and to allow the State to passively enroll all dual eligible members into the SNP component of the ADHS/DBHS plan. Without that authority, the State will have taken one step forward (integrating physical and behavioral) but one step backwards (un-aligning dual eligibles).

All of these factors outlined above – poorer physical health outcomes, concerns from the stakeholder community, the need for alignment at the health plan level, and others – support Arizona's request to move toward integration of physical health in an incremental manner by making the *behavioral health entity* – ADHS/DBHS – the lead entity responsible for the physical and behavioral health care of its members with SMI.

For these reasons, Arizona seeks to be waived from the provisions found at Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56 so that it can achieve integration and better health outcomes by requiring individuals with SMI to enroll with ADHS/DBHS for the treatment of their physical and behavioral health care conditions.

III. Public Process

The goal of designing an integrated system is to improve the overall health care and outcomes for AHCCCS members with SMI. In order to achieve this goal, obtaining input from peers and family members was critical to the State. Also important was a process to obtain input from providers in both the behavioral health and acute care systems.

To assist in this process, the State engaged St. Luke's Health Initiatives (SLHI), a Phoenix-based public foundation focused on Arizona health policy and strength-

based community development. For the consumer engagement process, SLHI worked in conjunction with members from the ADHS/DBHS Office of Individual and Family Affairs (OIFA) and a Peer and Family Engagement Workgroup designated by the Arizona Peer and Family Coalition to ensure member feedback during the State's review process. SLHI and a team of Peer leaders conducted a series of key interviews and focus groups with peers and family members.

Seven focus groups were conducted at organizations serving peers and family members of individuals with SMI as well as at the Arizona chapter of the National Alliance on Mental Illness (NAMI). SLHI conducted individual interviews with persons not affiliated with the organizations that participated in the focus groups. Additionally, ADHS/DBHS Office of Individual and Family Affairs conducted focus groups specifically for Spanish speaking peers and family members and African American members. In all, over 100 individuals with SMI and their family members participated as part of the consumer engagement process.

SLHI also conducted five focus groups and individual interviews with the provider community that included both acute care and behavioral health providers. In all, over 50 providers were contacted as part of the outreach process.

The results of this engagement were summarized by SLHI and their reports are forthcoming.

In addition, ADHS has an online survey accessible through their website and available to any individual who wishes to provide feedback throughout this process.

It is difficult to fully summarize the public engagement process, so the State prefers that CMS staff review the SLHI reports as they more fully capture the sentiments and thoughts of those who participated. However, the State does believe the public engagement process demonstrated support for a more holistic approach to healthcare, improving communication amongst the team of providers that work with individuals with SMI, and achieving greater accountability for the healthcare outcomes of this population. Additionally, the public engagement process confirmed that consumers' primary concern is maintaining choice of provider not choice of acute care health plan. In fact, the provider community overwhelming supports maintaining the current structure – that of one Regional Behavioral Health Authority for Maricopa County. Overall, the public engagement process supports the approach the State is seeking in this waiver request, provided that the State maintain ongoing dialogue with stakeholders and maintain sufficient flexibility to incorporate feedback, particularly from peers and family members where possible and appropriate.

The State also conducted tribal consultation on September 22, 2011 at AHCCCS and on January 18, 2012 at ADHS. The State views tribal consultation on this matter to be ongoing as issues related to American Indian members with SMI are unique since these members cannot be compelled into managed care. The State has also begun discussions with Indian Health Services facilities and the State will continue to work

with the Indian Health Services and tribally operated 638 facilities to design care coordination policies that will support tribal members with SMI that receive services through the AHCCCS fee-for-service program, known as the American Indian Health Program.

It is important to note that the State views the public engagement and tribal consultation process as an ongoing dialogue and the outreach discussed above is part of the first phase of this dialogue.

IV. Data Analysis- "With Waiver" vs. "Without Waiver"

The State does not anticipate any change to budget neutrality since the same services will be provided and the same populations are being served.

V. Allotment Neutrality

N/A. The amendment does not impact the XXI population.

VI. Details

A Modest Change in the Structure of Behavioral Health at ADHS/DBHS

Currently, AHCCCS acute care members requiring treatment of behavioral health conditions do so through the ADHS/DBHS. Specifically, AHCCCS members are assigned to a Regional Behavioral Health Authority (RBHA) that serves their geographic service area. ADHS/DBHS subcontracts with a RBHA through a formal competitive bidding process and awards five-year contracts to private entities. There is only one RBHA for each geographical service area, and only one RBHA that serves Maricopa County (Magellan).

The RBHAs are responsible for providing services to AHCCCS members in the areas of general mental health, substance abuse, crisis, and children's services. The RBHAs also serve a small portion of non-Title XIX eligible individuals with SMI. Under this waiver, if approved, the RBHA in Maricopa County will continue to provide all of the same services it does today, and it will also be responsible for the provision of physical healthcare to its members with SMI. The RBHA will be held to the same standards as any acute care managed care organization serving the State's Medicaid program currently. It will be the RBHA that will also be required to become a SNP to enable it to coordinate care for its dual eligible members with SMI.

Certainly, this waiver request represents a departure from the previous philosophy in the State of maintaining a separation of behavioral and physical health. However, the approach is incremental and makes only a modest change to the existing structure of healthcare delivery for AHCCCS members requiring treatment of behavioral health conditions. It is the State's desire to assess and analyze the success of this change and build upon it to further the integration process statewide for individuals with SMI

and eventually for other populations. However, this first step must be taken to ensure the building of a proper foundation and to allow sufficient time to properly assess this proposal.

Timeline

At this time, the State has a broad estimated timeline, which is subject to change depending on approval of this waiver request and other factors.

Public Meetings	September – December 2011 and ongoing
Request for Proposal Issued	July 2012
Proposals Due	October 2012
Contracts Awarded	January 2013
Readiness Reviews	February 2013
Transition Activities Begin	February 2013
New Contracts Effective	October 1, 2013

VII. Evaluation Design

The State would apply the same evaluation criteria to this proposal that it applies to the rest of its 1115 Demonstration. The evaluation would show that requiring one single entity (the Maricopa County RBHA) to be responsible for the physical and behavioral health care needs of individuals with SMI will improve health outcomes, increase life expectancy, reduce costs, and improve service delivery and care coordination. The evaluation will also demonstrate improved quality of care and reduced costs by aligning dual eligibles by requiring that the RBHA also be a SNP.

Attachment 1

AHCCCS SMI Medicare Enrollment as of December 1, 2011